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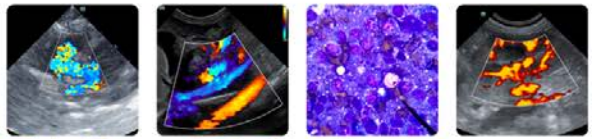


Clinical Sonography & Telecytology
Educational Teleconsultation Services™

PATIENT

Agnes Senior Dog Haven

SPECIES

Canine

BREED

Pomeranian x

SEX

Spayed Female

AGE

10 Years

WEIGHT

3 kg

INTERPRETED BY

Beth Johnson, DVM DACVIM

IMAGING PERFORMED BY

Renee Trionfetti, VMD

HOSPITAL NAME

East Bradford Veterinary Hospital

REFERRING VET

Meghan McGrath, DVM

INVOICE

72325

DATE

12/4/25

PRESENTING CLINICAL SIGNS

New intake for Senior Dog Haven Rescue with coughing. Needs Dental procedure. AUS to further evaluate elevated LES (ALT/ALP/GGT/ mild hypoalbuminemia) and hepatomegaly
on radiographs.as well as severe tracheal collapse throughout the thoracic inlet, VHS normal at 10.3. CBC - mild leukocytosis characterized by a mild neutrophilia and monocytosis. Other: Severe dental disease Meds: Doxycycline. Prev on Azithromycin in shelter.

Abnormal PE/Chem/CBC/UA Results: Reactive through sedation over the area of the right pancreas, tense, vocalized, jumped. Also, after shaving, noted small area of petechiae in the RUQ. Diagnostics: - AXR: Hepatomegaly. CXR: VHS 10.3, severe tracheal collapse throughout thoracic inlet - CBC: Hct 40%, Plts 621 H, WBC 16.1 H, Neut 12,719 H, Mono 1,127 H - Chem: Alb 2.3 L, Glob 3.7 H, TP 6.0-n, AST 47-n, ALT 198 H, ALP 1,666 H, GGT 21 H, BUN 34 H, Cr 0.6-n, Precision PSL 5,790 H (24-140) - UA: USG 1.024, inactive sediment, NSF - T4: 0.6 L - Keyscreen fecal: Cryptosporidium canis - Detected, reminder undetected - 4Dx: Neg x 4

ULTRASONOGRAPHIC EXAMINATION OF THE ABDOMEN

Urinary System

The urinary bladder is adequately distended with anechoic contents. No masses, inflammatory changes, echogenic sediment or cystoliths are observed. The urinary bladder, trigone and visible pelvic urethra are normal in thickness with a smooth mucosal surface.

Kidneys are overall normal in size and shape with smooth peripheral margination. A normal 1:3 cortex to medulla ratio is maintained. The medulla and cortices are uniform in texture with some mild increased cortical echogenicity and mild loss of corticomedullary distinction, expected in this age patient. There is no evidence of mineral or infarcts observed. Left kidney measures 3.5 cm. Right kidney measures 3.0 cm. Mild pyelectasia is present bilaterally.

Adrenal Glands

The right adrenal gland is normal in size (0.61 cm at cranial pole and 0.29 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

The left adrenal gland is normal in size (0.32 cm at cranial pole and 0.47 cm at caudal pole), shape and overall architecture, echogenicity and echotexture. Visible surrounding vasculature appears normal.

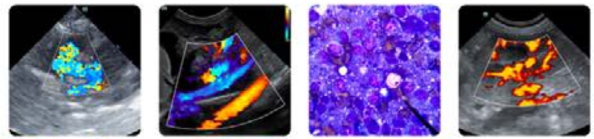
Spleen

The spleen is subjectively normal in size with a normal smooth capsular contour. Parenchyma is appropriately finely textured and homogenous with normal echogenicity relative to surrounding tissue (hyperechoic to liver). No focal nodules or masses are observed. Splenic vasculature appears normal.

Liver

Liver is subjectively enlarged with mildly irregular margins. Parenchyma is markedly heterogenous characterized by multiple poorly defined hypoechoic nodules within otherwise hyperechoic liver parenchyma. Visible vasculature and biliary tree appear normal without distension or congestion

The gallbladder is non-distended in size. The wall is smooth without visible thickening. Luminal contents are primarily anechoic. There is no evidence of cystic or common bile duct dilation.



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Gastrointestinal

The visible stomach wall is normal in thickness and layering. The lumen of the stomach is mildly distended with a small to moderate amount of echogenic non-shadowing luminal contents and gas consistent with normal ingesta. There is no evidence of obstruction, foreign material or infiltrative disease. Pyloric outflow tract appears patent.

The visible small intestines are normal in wall thickness and layering. Small intestinal motility appears adequate (1-3 contractions per min). The lumen of the small intestine is empty with no evidence of obstruction, foreign material or infiltrative disease.

The visible colon is normal in wall thickness (< 0.2 cm) and layering. Contents are consistent with normal formed feces and gas.

Pancreas

The observed pancreas is prominent (enlarged) in size, hypoechoic to surrounding tissue and irregular in shape with a swollen undulating contour. Enhanced hyperechoic ill-defined surrounding fat is noted.

Free Abdomen

There is no visible free peritoneal effusion noted in these images.

There is no apparent pathologic lymphadenopathy noted in these images.

PRIMARY FINDINGS

- Moderate to severe acute pancreatitis is suspected, visibly affecting primarily the right limb.
- The markedly heterogeneous liver could represent a benign change such as nodular hyperplasia, a steroid or vacuolar hepatopathy, extramedullary hematopoiesis, or chronic inflammatory disease. However, infiltrative neoplasia such as round cell neoplasia, metastatic neoplasia, other can't be ruled out without tissue sampling.

SECONDARY FINDINGS

- Age related kidney changes with mild bilateral pyelectasia.

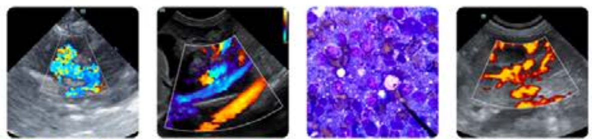
INTERPRETATION OF THE FINDINGS & FURTHER RECOMMENDATIONS

A gastrointestinal malabsorption panel (including cobalamin, folate, TLI and PLI) to Texas A&M GI Laboratory is recommended for further evaluation of GI and pancreatic function.

Three view thoracic radiographs are recommended for further assessment of cardio-pulmonary status as well as to further evaluate for any evidence of metastatic disease, if not recently evaluated.

Fine needle aspirates of the liver are recommended if patient's coagulation status is appropriate.

If not recently evaluated, a urinalysis and, if indicated based on urinalysis results, urine culture is recommended. If protein is present in an otherwise quiet sediment, protein quantification with a urine protein to creatinine ratio is recommended.



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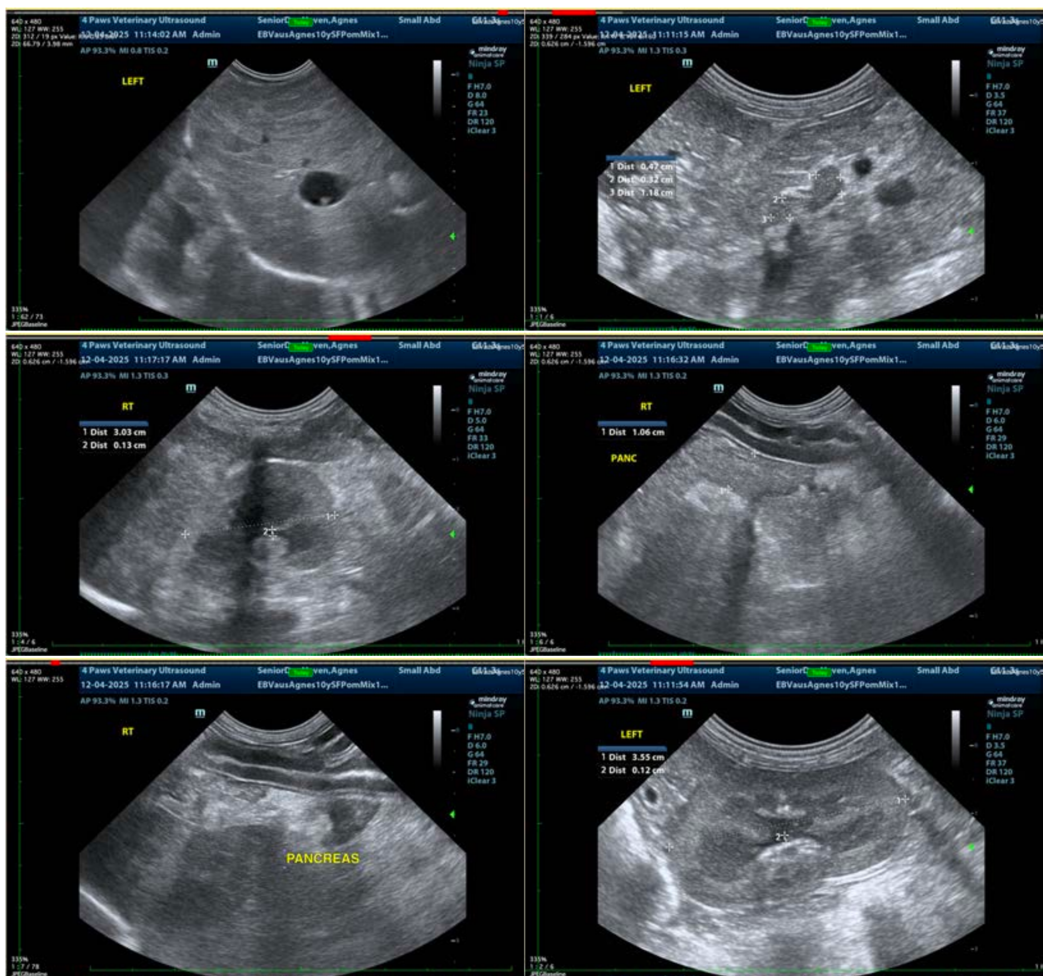
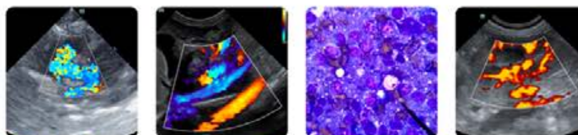
In the meantime, medical management of pancreatitis with anti-emetics, gastroprotectants, appetite stimulants or nutritional support as needed, pain management, broad spectrum antibiotics, and fluid therapy is recommended. If possible, a fresh frozen plasma transfusion and hyperbaric oxygen therapy (HBOT) could be beneficial. Monitoring of the pancreas with power doppler is recommended to identify possible necrosis as well as other potential sequelae such as abscesses, etc.

Pending patient's clinical response and laboratory values post hopeful resolution of the pancreatitis, additional hypoalbuminemia workup may be warranted if hypoalbuminemia persists and a diagnosis is not obtained, including a baseline cortisol, and potentially bile acids if patient's total bilirubin is not increased. If baseline cortisol is less than 2, a full ACTH stimulation test is recommended to rule out hypoadrenocorticism.





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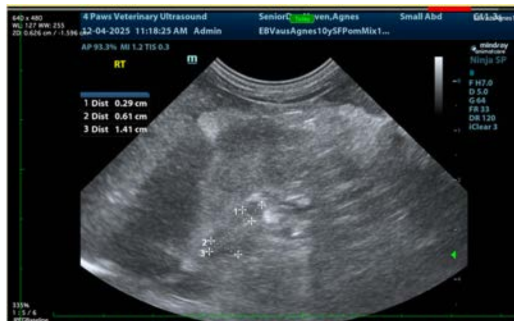

The information and recommendations provided are based on the images presented by the referring veterinarian/sonographer. No evaluation can be communicated regarding pathology that was not visible in the image/video clips provided.

Thank you for this referral. If the clinical or image interpretation does not parallel your findings or if I can be of any further assistance please contact me.

Beth Johnson, DVM, DACVIM
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